

# California Department of Public Health – Viral and Rickettsial Disease Laboratory

## Swine Influenza Specimen Submittal Form

Specimens should be collected within the first 24-72 hours of onset of symptoms and no later than 5 days after onset. Personnel collecting clinical specimens should wear an N95 respirator, goggles, disposable gown, and disposable gloves. Bronchoalveolar lavage specimens should be collected in a negative-pressure room using a Powered Air Purifying Respirators (PAPR).

### Respiratory Specimens:

- Each specimen should be labeled with: **date of collection, specimen type, and patient name.**
- At a minimum, collect a nasopharyngeal swab (nasopharyngeal wash or nasopharyngeal aspirate are also acceptable). Oropharyngeal (throat) swabs are acceptable, but may not have as high yield. If oropharyngeal specimens are collected, they should be accompanied by a specimen from the nasopharynx. Place the swabs in a standard container with 2-3 ml of viral transport media (VTM).
- If the patient is hospitalized with pneumonia, specimens from the lower respiratory tract (e.g., tracheal aspirate, bronchoalveolar lavage) should also be obtained.
- Use dacron-tipped swabs only. Cotton or calcium alginate swabs are **not** acceptable for PCR testing.

### Sera:

For cases or contacts of cases with confirmed swine influenza, collect as much blood as possible (recommended volumes 3- 10 cc from children and 10-20 cc from adults) in a serum separator tube (red top or tiger top). If possible, spin to separate sera before packaging.

### Specimen Storage and Shipment:

The specimens should be kept refrigerated at 4°C and sent on cold packs if they can be received by the laboratory within five days of the date collected. If samples cannot be received by the laboratory within five days, they should be frozen at -70 °C or below and shipped on dry ice. Specimens should be shipped per usual protocol to either your local public health laboratory or to:

*California Department of Public Health - VRDL Specimen Receiving / Swine Influenza*  
850 Marina Bay Parkway Richmond, CA 94804 (510) 307-8585

**---Please do not send specimens on a Friday or weekends unless special arrangements have been made with the laboratory---**

Patient's last name, first name				Patient's mailing address (including Zip code)		Route to: <input type="checkbox"/> PCR <input type="checkbox"/> ISOL <input type="checkbox"/> FA
Age	DOB:	Sex (circle): M    F	Onset Date:	COUNTY: _____		
Disease suspected <u>or</u> test requested - Check one: <input type="checkbox"/> Influenza <input type="checkbox"/> other respiratory virus						
1 <sup>st</sup>	Specimen type and/or specimen source		Date Collected	1 <sup>st</sup>		
2 <sup>nd</sup>	Specimen type and/or specimen source		Date Collected	2 <sup>nd</sup>		
Type or print submitter's complete mailing address				Carol Glaser, DVM, MD, Chief Viral and Rickettsial Disease Laboratory 850 Marina Bay Parkway Richmond, CA 94804 Phone (510) 307-8585    Fax (510) 307-8578		

### Local Laboratory Results:

Was this specimen tested by a rapid antigen test?    ☐ Yes    ☐ No    If yes, result: ☐ Pos    ☐ Neg  
 Was this specimen typed as Influenza A?    ☐ Yes    ☐ No    If yes, was subtype identified?    ☐ Yes    ☐ No

***If this sample could not be sub-typed, please alert VRDL and provide the ETA and Tracking #***

### Epidemiologic and Clinical Information (Please attach clinic/hospital notes and laboratory data)

Travel to Mexico in past 30 days? <input type="checkbox"/> Yes <input type="checkbox"/> No Contact with pigs? <input type="checkbox"/> Yes <input type="checkbox"/> No Contact of lab-confirmed swine flu case? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what type of contact? Household <input type="checkbox"/> HCW <input type="checkbox"/> Other close contact <input type="checkbox"/> Outbreak setting? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, type of setting (school, LTCF etc):	<input type="checkbox"/> Fever to _____°F <input type="checkbox"/> Cough <input type="checkbox"/> Sore throat <input type="checkbox"/> Nausea/vomiting/diarrhea <input type="checkbox"/> Altered Mental Status <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Other, please describe: Is patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No Is patient in the ICU? <input type="checkbox"/> Yes <input type="checkbox"/> No Antiviral treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list drug and start date:
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Submitting Physician: \_\_\_\_\_ Phone# (\_\_\_\_\_) \_\_\_\_\_

Submitting Facility: \_\_\_\_\_ Fax# (\_\_\_\_\_) \_\_\_\_\_